Montana Patient Centered Medical Home (PCMH) Initiative: Framework for Payment

Montana's Definition for Patient-Centered Medical Home

> ***In Montana, a patient-centered medical home is health care directed by primary care providers offering family centered, culturally effective care that is coordinated, comprehensive, continuous, and, when possible, in the patient's community and integrated across systems. Health care is characterized by enhanced access, an emphasis on prevention, and improved health outcomes and satisfaction. Primary care providers receive payment that recognizes the value of medical home services.***

Standard for Recognition

Montana will use standards accepted by NCQA PCMH to recognize a primary care clinic as eligible for the pilot project as a medical home and potentially to receive enhanced reimbursement. Pilot sites will commit to moving along the NCQA tiered recognition process. Those recognized as Level 1 under NCQA PCMH 2008 standards must reach 2008 Level 2 or higher or 2011 Level 1 or higher by January 1, 2013. Details on NCQA PCMH Recognition can be found at http://www.ncqa.org/tabid/631/Default.aspx

Summary:

Achieving the vision of PCMH in Montana requires a framework that creates:

- a payment mechanism that incents providers to invest in the infrastructure of the PCMH
- a reduction in total cost of care (TCOC) for sustainable support by payers
- demonstration of improved care coordination for chronic disease
- measurement and improvement of quality outcomes for patients including access, experience of care, and prevention; identification and closure of gaps in care
- the engagement of patients, providers and payers in education and promotion of the PCMH model

The framework requires agreement on operating principles for providers and payers that creates mutual value.

Attribution

A critical factor for success of the PCMH model is to link the patient (member) to a primary care provider within a Patient Centered Medical Home. All of the mutual benefits occur when a patient seeks care preferentially at the PCMH; the medical home assumes accountability for the health of their patients (panel) and the outcomes are measured over time by payers for this group (population.)

The ideal attribution is that obtained through patient choice at time of payer enrollment. This allows for member education and encouragement to utilize services at PCMH practices rather than venues that are disconnected or higher cost. (Patients may change this provider election at any time, but must communicate this fact to their payer according to their rules.)

There is also a need for secondary methods of attribution of those not choosing enrollment. Assignment algorithms based on prior PC visits or provider attestations may be needed to complete the attribution. All attribution methods require ongoing communication between payers, providers and patients to reconcile the dynamic relationships that exist. Applying attribution to all members of an insured group is the cornerstone of encouraging PCMH practices to perform non-RVU activities and outreach to members for health/prevention services.

Since the PCMH Initiative is a voluntary system, we need to recognize that payers have multiple groups under contract and not all of them may participate. Thus attribution of members is limited to those groups.

Payment Schema

Services currently recognized under Fee for Service billing will be charged by PCMH practices and reimbursed by payers as currently performed. The PCMH practice will additionally be reimbursed for care of attributed members through a 3-part process:

- **Participation**

  All payers will pay PCMHs a <u>defined monthly fee per attributed member</u> to recognize the non-RVU activities that are intrinsic to the PCMH model and require infrastructure and operational investment. These activities include identification and closure in gaps of care. <u>Payers will pay this automatically</u> once attribution is verified between parties as long as coverage continues.
  Future development of the PCMH Initiative may allow for differential payment to practices for higher levels of PCMH recognition that implies increased resource utilization.

- **Chronic Disease Management (CDM)**

  An additional monthly payment will be paid for every attributed patient with certain qualifying diagnoses that are known to be associated with higher utilization of resources and overall cost of care. Providers will need to bill the respective payers using special codes (HCPC) established for this purpose.

  The initial diagnoses recognized for the CDM payments include: Diabetes Mellitus, Heart Failure, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, Hypertension and Asthma. Other diagnoses may be added to the qualifying list in the future for the pilot initiative or by an individual payer at their discretion. An increased payment may be recognized by a payer for two or more qualifying diagnoses in a single patient.

  The CDM payment allows PCMH practices to invest in software and personnel to perform case management activities to ensure education and patient compliance with medical regimens that avoid emergencies and hospitalizations.

- **Quality**

  It is essential that quality measures are captured and reported at a state level with a degree of transparency that promotes credibility and accountability. Reducing TCOC without maintaining/improving quality does not create value. Quality measures that are recommended by the PCMH Advisory Council include measures that incorporate Evidence-based Best Practices in the care of chronic diseases, prevention, access, and patient experience.

  PCMHs will receive an annual payment dependent on performance on designated quality metrics. This payment would be initiated by the payer, after verification of data and based on the number of members attributed to that PCMH.

  A statewide data base will be created to accept reports on the quality measures. The Advisory Council will recommend prospectively the target scores for each measure that trigger payment. The quality measure scores will be based on a statistically valid number for each PCMH's attributed population.

  If the Quality Measure reporting/payment feature is delayed due to technical or logistical issues, it should not affect the other two payment structures in the implementation of the PCMH Initiative pilot.

Other Considerations

Critical success factors for the PCMH Initiative are data sharing and communication, which will need to occur at the various levels of relationships among payers, providers and their shared patients. A state-wide platform for benchmarking and potential public reporting is desirable.

This framework is intended to serve as a guideline for payers in creating contract amendments that incorporate payment for PCMH into their current provider agreements.

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